June 1998

California Morbidity

Department of Health Services
S. Kimberly Belshé, Director

State of California
Pete Wilson, Governor

Testing for HIV in California: Volume and Seropositivity in Private versus Public Sites

Counseling about risks for human immunodeficiency virus (HIV) infection and phlebotomy for HIV testing may be performed at public or private sites. Since 1985, counseling and testing data from public test sites have been used extensively for HIV prevention planning at the state, regional, and local levels. Although studies have examined the sources of specimens for HIV testing,[1-4] to our knowledge no specific data for California are available. This report summarizes the results of a survey of laboratories in California to determine the relative proportion of HIV tests and seropositivity rates from private versus public test sites.

In 1995 a standardized questionnaire was sent to directors of all 412 laboratories licensed to conduct HIV antibody testing in California. We classified the laboratories as private (including hospitals, blood banks, plasma centers, and out-of-state laboratories) or public. From the 385 laboratories eligible to participate, we obtained a 58% response rate (43% percent of private and 98% of public laboratories returned our survey). The survey instrument asked for information on the numbers of enzyme-linked immunosorbent assay (ELISA) tests performed and of confirmed HIV positive results by type of testing site. We classified the testing sites into private (blood banks, insurance companies, private medical doctors, and health maintenance organizations), public (state and county facilities, family planning clinics, drug treatment clinics, and sexually transmitted disease clinics), other (universities and immigration sites), or unknown.

The majority (90.6%) of specimens tested at public laboratories came from public test sites. At private laboratories, the majority (86.3%) of specimens came from private test sites. Overall, 76.4% of specimens came to the laboratories from private test sites (Table 1). Public test sites had a higher HIV seropositivity (2.26%) compared with private test sites (0.09%). Approximately one in seven (14.4%) HIV positive test results in our survey came from private testing facilities.

Editorial Note: In several studies, the private sector was the source of more than 60% of voluntary HIV tests. [1-4] Our survey results on testing volume are consistent with these studies. On the other hand, the seropositivity for private test sites in this study (0.09%) was much lower than in a previous study reported from Oregon (1.4%).[1] The reasons for this discrepancy are unknown.

While our survey data from public laboratories were nearly 100% complete, our response rate from private California laboratories was less than 50%. Given that the majority of specimens tested at private laboratories came from private test sites, the relative contribution of HIV positive results from private test sites likely represents a low estimate of the true percentage. Thus, California's HIV prevention strategies based on public test site data include demographic and risk behavior information from a maximum of 86% of all HIV positive results.

This study had several other limitations. First, we do not know how the seropositivity rates among non-responding laboratories differ from the rates among responding laboratories. Second, we have no data on age, ethnicity, sex, previous test results, reason for testing, and behavioral risks for HIV among persons tested. These variables are important to prevention research, which can translate into applied prevention programs.[5] Finally, because no identifying patient information was collected, these data represent tests, not individual persons.

The predominance of HIV tests (not positives) from private test sites suggests a need to evaluate HIV counseling and testing in this sector.[6,7,8] Such an evaluation may aid in determining the quality and effectiveness of counseling and prevention messages, and may assist individuals to adopt and maintain low or no-risk behaviors.[9] Future research on the type of behavioral messages disseminated in the private sector would assist in decreasing the spread of HIV in California.

Table 1. Number of ELISA tests and HIV seropositivity by type of test site where specimens were collected -- California, 1995

	Tests		Positive Tests		Seropositivity
Test Site Type	**Number**	**Percent**	**Number**	**Percent**	**Percent**
Private	1,733,335	76.4	1,621	14.4	0.09
Public	315,795	13.9	7,122	63.3	2.26
Other	18,015	0.8	129	1.1	0.72
Unknown	200,974	8.9	2,376	21.1	1.18
TOTAL	**2,268,119**	**100.0**	**11,248**	**100.0**	**0.50**

References

1. Centers for Disease Control and Prevention. Testing for HIV in the public and private sectors -- Oregon, 1988-1991. MMWR 1992;41:581-4.
2. Centers for Disease Control and Prevention. HIV counseling and testing services from public and private providers -- United States, 1990. MMWR 1992;41:743,749-52.
3. Centers for Disease Control and Prevention. HIV counseling and testing -- United States, 1993. MMWR 1995; 44:169-74.
4. Anderson JE, Brackbill R, Wilson RW. Diagnostic HIV antibody testing in the United States: the role of private providers and public programs. AIDS 1996;10:342-3.
5. Truax S. On the new call for HIV prevention research. Am Psychol 1994;49:1092-3.
6. Higgins DL, Galavotti C, O'Reilly KR, et al. Evidence for the effects of HIV antibody counseling and testing on risk behaviors. JAMA 1991;266:2419-29.
7. Pazin G. Counseling must precede testing for HIV/AIDS. Pennsylvania Medicine 1991; 94:24-5.
8. Centers for Disease Control and Prevention. Public Health Service guidelines for counseling and antibody testing to prevent HIV infection and AIDS. MMWR 1987;36:509-15.
9. Gerbert B, Maguire BT, Coates TJ. Are patients talking to their physicians about AIDS? Am J Public Health 1990;80:467-9.

Reported by: Arthur Johnson, BA, Fred Molitor, PhD, Richard Sun, MD, MPH, HIV/AIDS Epidemiology Branch, Office of AIDS, California Department of Health Services.

Note to Authors: Articles should be submitted to CM Editor, DCDC, CA Department of Health Services, 2151 Berkeley Way, Berkeley, CA 94704. Length should be approximately 1000 words or less. Tables, figures, and other materials can be included as supplements. References should be numbered sequentially. Submit typed, double-spaced hard copy of text and tables along with electronic copies, preferably in Word or Wordperfect, Macintosh or Windows, on a floppy disk. Graphics may be in a graphic format. Submissions can be e-mailed to *jrosenberg@dcdc2.dhs.cahwnet.gov*. Acknowledgments as to source will be provided, and may be individuals and/or programs as suggested. Publication in *CM* should not preclude publication elsewhere.